Treating Depressed Patients with Comorbid Trauma

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Learning Objectives

• By the end of this training, participants should be able to:
  – Discuss recent trends in trauma care and how this can influence depression care
  – List ways in which trauma can IMPACT each stage of the IMPACT workflow
    • Recognize patients with trauma history
    • Assess impact of trauma on current functioning and ability to engage in depression treatment
    • Initiate treatment for depression even in the presence of trauma history
    • Identify patients who need to have more intensive trauma treatment
Why are we talking about trauma?

• Common
• Can prevent engagement
• Can prevent remission of symptoms
• Bidirectional problem
  – focusing on it and not focusing on it can affect engagement and/or remission of depressive symptoms
Exposure to traumatic events is relatively common (Kaysen, 2009)

- 39% - 90% of Americans endorse lifetime traumatic stress exposure
- 20% endorse current (past year) exposure
- 50% of people exposed to one event have multiple incident exposures
Trauma: New fad or new treatment horizon?

• Trauma-informed care
• ACE’s
• Evidenced-based trauma treatments
The ACE study findings suggest that certain experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. \(^1\)
ACE study

http://www.cdc.gov/violenceprevention/acestudy/pyramid.html
Be careful

• Correlation versus causation
• Causation versus what treatment is most effective
Prevention of this ACE process?

• This study doesn’t tell us what will mitigate these effects if they have already happened

• Main indication of the ACE study is intervention early in households at risk for childhood incidents may prevent this process
Trauma-Informed Care

• A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. SAMHSA

• Not adding to a patient’s trauma or re-traumatization of patient
Resiliency: the positive side of trauma

- The tendency to adapt to risk or adversity
- Helps people recover from adverse incidents
- Higher resiliency makes a patient less likely to develop PTSD
- Restoring these in treatment for depression may restore their ability to cope with trauma
Resiliency

• **Whatever does not kill us, *JPSP*, 2010**
  - Longitudinal study demonstrating u-shaped relationship between adverse life events and MH/well-being

  - Resilience was common despite high levels of trauma exposure and PTSD
  - 10-item self-report resilience scale
Be careful

• Reality that patient has trauma does not absolutely lead to a need to deal with trauma all of the time

• Approach at Kaiser and many other systems - outpatient psychiatry - not ready for dealing with childhood sexual abuse/other trauma if depressed
IMPACT Workflow: Identify & Engage

Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Identify and Engage

• Assess trauma but not re-traumatize
• Focus on function
• PCL-C
Tips for asking about trauma

#1
To prevent re-traumatizing/dissociation and triggering of PTSD symptoms...

- Encourage short, concise descriptions of the trauma
  - ask for 2-3 sentences or 25 words or less to get a general sense of the trauma
  - be directive and feel free to stop the telling if you see the patient getting upset
  - Normalize the extreme difficulty patients often have in re-telling their stories

#2
Because patients...
- Often have unique post-injury concerns
- Interpret trauma uniquely
- Post injury distress may be described differently

Don’t start with a checklist
- Encourage them to tell their story in their own words
- Use open-ended questions

Remember, you don’t need the details to make the diagnosis or treat depression

#3
If patient dissociates...
- Help the patient ground themselves by directing them to engage in their immediate environment
- Once grounded, educate on dissociation
3 Critical Elements of Engagement

- Goals?
- Tasks?
- Bond?

All 3 must be agreed upon by patient & provider
Let’s set aside your rhythm issues for a moment and work on your blues
Assess patient’s desire for treatment of trauma

• What brings you to see me? What are you expecting in this visit today?
• What are you hoping to get from your care?
• If you push trauma treatment many will probably take it - but is this best for them?
Assessing whether to work on trauma or not

- Is this a foreground issue or a background issue?
- Are you experienced and fully trained in an evidenced based approach?
- Could this be resolved in a short time frame?
- Is the patient likely to get worse before better and can our system handle that? Can the patient handle that?
IMPACT Workflow: Establish a Diagnosis

Identify & Engage

Establish a Diagnosis

Initiate Treatment

Follow-up Care & Treat to Target

Complete Treatment & Relapse Prevention

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Establish a Diagnosis

- They need to each have a diagnosis of depression
- Diagnosis of PTSD vs. past history of trauma
- Use caseload consultation to help differentiate
Does trauma always cause PTSD?

Most people *do not* get PTSD as a result of trauma
(i.e., post Katrina, 9/11 studies, combat)
70-90% of people report having had at least one traumatic experience
(Breslau, 2002; Kessler et al., 1995)

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<td>• 6.8% of all adults;</td>
<td>• Vietnam War: 30.9% men, 26.9% women</td>
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<tr>
<td>• 3.6% men, 9.7% women</td>
<td>• Gulf War: 10.1%</td>
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<td>• OEF/OIF (2008): current prevalence 13.8%</td>
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PTSD & Depression

Patients with PTSD & MDD in primary care:
Campbell et al. (2007)
- More severe depression
- Lower social support
- More likely to report suicidal ideation
- More frequent health care visits

30%-50% of PTSD patients have significant depressive symptoms
PTSD Symptoms

Criterion B
- Flashbacks
- Distressing recollections
- Dreams
- Physiological reactivity
- Psychological distress at reminders

Re-experiencing (1)

Criterion C
- Thoughts, feelings, & conversations
- Activities/Places/People
- Amnesia
- Detachment
- Loss of interest
- Restricted affect
- Foreshortened future

Criterion D
- Sleep difficulties
- Hyper-vigilance
- Irritability & anger
- Startle
- Concentration

Avoidance (3)

PTSD

Post
- traumatic
- Stress
- Disorder

Kaysen, 2009
# PTSD Checklist Four Item Screen

**In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you...**

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<th>Yes</th>
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<td>Had nightmares about it or thought about it when you did not want to?</td>
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<td>Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?</td>
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<td>Were constantly on guard, watchful, or easily startled?</td>
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<td>Felt numb or detached from others, activities, or your surroundings?</td>
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PTSD Screening

- The total score is the sum of all 17 items
- A score of ≥ 45 suggests the presence of a significant level of symptom severity
- Goal: 50% drop in score or < 30

IMPACT Workflow: Initiate Treatment

- Identify & Engage
- Establish a Diagnosis
- Initiate Treatment
- Follow-up Care & Treat to Target
- Complete Treatment & Relapse Prevention
Initiate Treatment

• First step is most often focus on depression
• BA and PST can be used to help the avoidance symptoms
• Antidepressants can also help PTSD symptoms
• Special considerations if patients have PTSD
  – Consider prazosin to target nightmare
  – Avoid benzodiazepines
WHO stress guidelines, 2013

• Trauma-focused tx’s should be provided to adults with ASD or PTSD if provider is trained; otherwise, stress management

• If moderate-severe depression is concurrent, provider should follow WHO depression guidelines as well
Comorbid treatment can usually be provided in PC setting (lots of caveats re: provider comfort/skills; specialty provider availability, etc.), but more severe comorbidities should be referred to specialty or at least consultation sought.
## Cautions for CBT in PTSD

### Iatrogenic Dangers:
- Exposure with no coping or habituation
- Repressed memories
- Exploring the past in psychotherapy

### Required for engaging Trauma Focused CBT (gold standard tx):
- able to come to sessions
- support
- resources available
- adequate mental status
- coping skills
BA and PST for PTSD

Goals
• Increase activity levels
• Prevent avoidance behaviors
• Increase positive and rewarding activities

What to do?
• Identify current avoidance behaviors and activities that are valued and rewarding
  – Depressive avoidance: do behaviors result from feeling depressed and is anxiety reduced
  – Do behaviors function to reduce anxiety/fear
  – Do behaviors lead to functional impairment and depression
• Evaluate obstacles for doing these activities
• Set goals for number and frequency and track in session
Other Skills to Manage Anxiety Symptoms

• Deep muscle relaxation
• Breathing relaxation
• Preparing for a stressor
• Active problem solving
• Attention to health habits
  – caffeine, alcohol, sleep, deconditioning, substance abuse
IMPACT Workflow: Follow-up Care and Treat to Target

Identify & Engage
Establish a Diagnosis
Initiate Treatment
Follow-up Care & Treat to Target
Complete Treatment & Relapse Prevention
Follow-up and Adjust Treatment

• Important to consider if patient’s depression is not responding
• When to consider referral to specialized care
Follow-up Considerations

- Watch patient’s PHQ-9 carefully
- Watch their response to treatment - feelings at end of session
- Maintain brief nature of interventions
- Consult regularly - more often than 8 weeks
- Change treatment if patient is having difficulties
Contraindications for prolonged exposure

*Euro J Psychotraumatology, 2012*

- Patients with depression much more severe than their PTSD or patients with current suicidal intent and behavior, as discussed above, are routinely excluded from PTSD trials, as clinically appropriate care would require stabilizing these issues prior to addressing their PTSD.
Consultation and Considerations for Referral for Specialty Care

- Patient has a high PTSD - PCL-C score above 45
- Patient isn’t improving with either or both PCL and PHQ over a period of time
- You aren’t trained in an evidenced-based approach for this trauma and patient needs more specific care
- Patient is responding but will need longer term care
IMPACT Workflow: Relapse Prevention

1. Identify & Engage
2. Establish a Diagnosis
3. Initiate Treatment
4. Follow-up Care & Treat to Target
5. Complete Treatment & Relapse Prevention
Relapse Prevention

• Consider both depression and trauma triggers
• Highlight the cognitive and relaxation techniques that have been helpful - making specific connections when you can
Selecting a Case

Follow-up Case Call
Wednesday, June 10th, 10:00-11:30am

Case Presentation Form

Case Presentation for Trauma and Depression

1. Choosing a Case

Look at your caseload and find a patient with a trauma history - not hard. Find someone you are doing trauma treatment with or thinking of doing trauma treatment with. Think of someone whom you took a depression treatment focus with and how is this working. You can also think of someone who started IMPACT since the presentation and explain what you did in engagement, diagnosis or treatment planning that followed the presentation guideline.

You can pick a successful case or one that has been challenging for you!

2. Prepare Case Presentation

Complete the following for the patient you've chosen.

Age:

Gender:

Diagnoses:

Basic demographic info (no PHI or information that could inadvertently identify a patient - please!): For example, living situation, stressors, strengths, factors affecting treatment course/outcome:

PHQ-9 at Baseline:

Most recent PHQ-9:

Length of time in treatment (# weeks or months):

Trauma

PCL- if done

Diagnoses, treatment goals:

Treatment:

Medications: If medication is part of treatment plan, what is current dose and regimen?
Was dose adjusted during the course of treatment? Is medication helping?

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